TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Spine and Joint

Respondent Name
East TX Educational INS Assn

MFDR Tracking Number
M4-17-2234-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital billed CAS, but a payment of $12,962.27 was made and the remainder was denied… More specifically, the implant charges were denied because they lacked proper certification… our position is that the Hospital is still entitled to additional reimbursement on the implant invoices because it provided the implant invoices as soon as it was able to, which had already been previously submitted."

Amount in Dispute: $55,017.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill did not document separate [reimbursement for] implants were being requested per Rule 134.40(f)(1)(B)…It is our position that by not following Rule 134.40 (f)(1)(B) 134.40(g)(1), our processing of these charges without separate reimbursement of implants was correct. We further maintain no further reimbursement would be due, as the request for separate implant reimbursement was filed past timely filing of a reconsideration."

Response Submitted by: Claims Administrative Services, Inc. 501 Shelley Drive, Tyler, Texas 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 23 through 25, 2016	Outpatient Hospital Services	$55,017.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out required billing forms/formats.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements
   - 29 – The time limit for filing has expired
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
   - 307 – Per 133.250, a reconsideration shall not be submitted alter than 11 (<07/01/12) or 10 (>=07/01/12) months from the date of service
   - 350 – Bill has been identified as a request for reconsideration or appeal
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking separate reimbursement for implantables that were provided as part of the outpatient hospital services in dispute. The hospital in this case argues that it should have been paid separately for the implantables.

   According 28 Texas Administrative Code §134.403(f)(1), the maximum allowable reimbursement (MAR) for outpatient hospital services such as those in dispute shall be (A) 200% of the Medicare allowable, **unless** (B) a facility **requests** separate reimbursement for implantables. 28 Texas Administrative Code §133.10 (f)(2)(QQ) furthermore **requires** that the hospital use a specific field on the UB-04 to make such a request for separate reimbursement:

   > (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted medical bills finds that neither the original billing, nor the bills submitted for reconsideration contain the required data in field 80. For that reason, the Division finds that the carrier in this case correctly deferred to the higher 200% rate outline in §134.403(f)(1)(A) as noted in its explanation for benefits.

   Because the requestor failed to support that it requested separate reimbursement in accordance with the applicable rules, the Division finds that no additional reimbursement is due. The hospital's assertion that other requirements were met, including those outlined in §134.403(g), are moot given the hospital failure to include the remarks in field 80 of the UB-04 required to trigger separate reimbursement for implantables.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 18, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
		May 18, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.